Collaborative Behavior Solutions
Helping Kids Connect in the World

2630 S. Arlington Ave.
Indianapolis, IN 46203
Phone: (317) 522-1956
Fax: (317) 522-1956

Mission Statement:

The mission of Collaborative Behavior Solutions is to provide individualized behavioral services to children to enhance their lives as well as their family.
Collaborative Behavior Solutions will use the fundamental principles of Applied Behavior Analysis to guide and direct programming and behavior analysis to help children with special needs reach their full potential. Each program will be individualized to meet the unique needs of each child. We use the child's strengths to help teach and overcome their challenges. Our goal is to work with families to produce a program that will help enhance the lives of the children as well as their families.

Services:

CBS provides 1:1 ABA (Applied Behavior Analysis) therapy up to 4:1 therapy for children with special needs. This therapy can take place in home, in a center, at school, in the natural environment, on a soccer field or wherever a child may need services. Children typically start with a 1:1 therapy and move to a larger ratio to prepare them for learning in a group environment. Each program designed is created individually for that child. Therefore, all therapies look different. Listed below are some of the possible services that CBS can provide.

Toilet Training
Individual Programming
Behavior Analysis
Socialization Skills Training
Community Involvement Programs
School Interventions
Collaboration and Wrap Around Services with all other interventions or schools

Life Skills
Family Interaction Programming
Learning Readiness Programming
Parental Support
Sensory Integrated Programs
Advocacy for IEPs and School Collaboration

Integration in a church or religious program for your child

Goals:

- √ Provide support and training for families and care givers to assist them in meeting daily life challenges.
- √ Develop honest and effective working relationships with our families
- √ Offer services to local schools and physicians
- √ Contribute to the community by furthering its growth and progress to improve the lives of families with children with development challenges.
- √ Provide comfortable place of employment for professionals
- √ A place where children's needs are first

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Collaborative Behavior Solutions: New Patient Information

_____
Today's Date

_____ _____ _____ _____ _____
Last Name First Name MI DOB Sex

_____ _____ _____ _____
Street Address City State Zip

Financial Responsible Party

_____ _____ _____ _____ _____
Last Name First Name MI DOB Sex

_____ _____ _____ _____
Street Address City State Zip

_____ _____ _____
Home Phone Work Phone Cell Phone

Insurance Information

Primary Insurance	Secondary Insurance
Insurance Company: _____	Insurance Company: _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber DOB: _____	Subscriber DOB: _____
Address: _____	Address: _____
ID#: _____	ID#: _____
Group #: _____	Group #: _____
Insurance Phone #: _____	Insurance Phone #: _____
Primary Care Physician: _____	
Primary Care Physician Phone #: _____	

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Authorization and Release

I authorize Collaborative Behavior Solutions, or it's agents to release and or all medical records or information necessary to process medical claims. I authorize a copy of this authorization to be used in place of the original and request payment of benefits either to myself or to the above provider who acquires assignment. I acknowledge that I remain financially responsible for unpaid co-insurance and deductible balances and amounts not covered by commercial third party payers.

_____

Signature of Responsible Party Date

Initial Assessment

Instructions: Please fill this document out to the best of your ability. Include copies of relevant information where noted.

Areas:

- ☐ Caregiver Information
- ☐ Child Information
- ☐ Diagnosis Information
- ☐ Medical Information
- ☐ Therapies and Services
- ☐ Education Information
- ☐ Current Programs
- ☐ Narrative
- ☐ Functional Assessment: Please include any behavior plans that have been written.
- ☐ Child Preferences
- ☐ Expectations
- ☐ Preferred Therapy Schedule
- ☐ Behavioral Language Assessment: Please include a copy of other similar assessments and/or a completed ABLLS.
- ☐ Copy of Child's IEP or Service Plan
- ☐ Copy of Child's Past and Current Behavior Plans
- ☐ Copy of Language Assessments (VB-MAPP, ABLLS)
- ☐ Date of Assessment: _____
- ☐ Date of Written Assessment: _____

Date Completed _____ /_____ /_____

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Caregiver Information

Parent/ Guardian #1

_____ _____ Relationship to Child: _____
First *Last*

Address: _____ Home Phone: (_____) _____-
Street Address

_____ _____ Cell Phone: (_____) _____-
City *State*

_____ Email _____
Zip

Parent/ Guardian #2

_____ _____ Relationship to Child: _____
First *Last*

Address: _____ Home Phone: (_____) _____-
Street Address

_____ _____ Cell Phone: (_____) _____-
City *State*

_____ Email _____
Zip

# of Adults in Household: _____ Names: _____

# of Children in Household: _____ Names: _____

Child Information

Child _____ DOB: ____/____/____ Age: _____
First *Middle* *Last*

Sex: M F SS#: _____-_____-_____

Address: _____ Home Phone: (_____) _____-
Street Address

_____ _____ Contact Phone: (_____) _____-
City *State*

_____
Zip

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Diagnosis Information

Primary Diagnosis: _____ Date of Diagnosis: ____/____/____ Diagnosing Physician: _____ Age at Diagnosis: _____

Secondary Diagnosis: _____ Date of Diagnosis: ____/____/____ Diagnosing Physician: _____ Age at Diagnosis: _____

Other Diagnosis: _____ Date of Diagnosis: ____/____/____ Diagnosing Physician: _____ Age at Diagnosis: _____

Date of Last Psychoeducational Evaluation: ____/____/____

Medical Information

Is the child on Medication? **YES** **NO**

Name of Medication	Dosage	Administration Times	Reason for Use	How Long Taking this Medication?

Has the child ever been admitted to a hospital or treatment center for: Psychiatric Situation: **YES** **NO** Behavioral Situation: **YES** **NO** Crisis Situation: **YES** **NO**

If answered "YES" to any of the above, please explain:

Please summarize the hospital/treatment facilities observation, treatment(s), and effectiveness of treatment(s):

Are there any medical conditions that need to be considered when delivering ABA treatment? **YES** **NO**

If "YES" please explain:

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Therapies and Services

What other services is the child **currently** receiving both in-school and out of school? Please enclose a copy of the child's most recent IEP and Therapy goals for each area that is checked.

☐ ESE Services in school	☐ Speech and/or Language therapy in school	☐ Occupational and/or Physical therapy in school	☐ _____
☐ Vision services in school	☐ Hearing services in school	☐ Aide/Paraprofessional assistance in school	☐ _____
☐ Early Intervention	☐ Developmental Services/Children and Families support in the home	☐ _____	☐ _____

Please describe the results of these therapies: _____

Education Information

Does the child attend school? **YES** **NO**

Name of School:_____

Grade Level: _____

Current Programs

Please indicate what current programs you, your therapists, and/or your teachers are working on with your child OR include a copy of current program list and IEP.

Narrative

In the space provided below, please describe your child's ability to follow simple instructions, cooperation with peers and adults, behavior issues, communication, and the child's best qualities.

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Behavioral Information

Please list and describe any problem behaviors that interfere with your child's cooperation and learning.

1. _____
2. _____
3. _____
4.

Have physical restraint, mechanical restraint, or medication been used to reduce these behaviors because the child was in danger of hurting themselves, others, or substantial property damage? **YES NO**

If "YES" please explain:

_____

Consider the behaviors listed above, and check all of the following that apply. *(There is additional space for notes on page 7 if necessary.)*

□ Does the behavior occur during certain seasons of the year?

_____ _____

□ Could the behavior be the result of any type of physical discomfort? (head/ stomach ache, dizziness, blurred vision, pain, etc.)

_____

□ Could the behavior be signaling some deprivation condition? (thirst, hunger, lack of rest, etc.)

_____

□ Could the behavior be a side effect of medication? (tired, unsteady, thirst, confused, toxic levels)

_____

□ Could the behavior be the result of a medical condition? (Seizures, PKU, allergies, CP)

_____

□ Are there any circumstances in which the behavior ALWAYS occurs?

_____

□ Are there any circumstances in which the behavior NEVER occurs?

_____

□ Does the behavior occur during certain times of the day?

_____

□ Does the behavior occur with certain people?

_____

□ Could the behavior be related to any skill deficits? (communication, excessive task requirements, physical ability)

_____

□ Is the behavior related to any particular activities?

_____

□ Is the behavior in response to aversive stimuli? (Tone of voice, being ignored, placing excessive demands, noise level, number of people in the room, lighting, change in routine, transitions)

_____

□ What does the behavior allow the child to gain? (attention, preferred activities or items)

_____

□ Does the behavior allow the child to postpone, avoid or escape aversive stimulation? (un-preferred activities, demands, social inter action, pain)

_____

□ Does the behavior provide self-stimulatory activity?

_____

□ Does the behavior occur collateral with any other behavior or as a part of a chain of behaviors?

_____

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□ Does the behavior occur as a result of having a preferred activity terminated?
_____

Describe the situations in which the problems behavior is MOST likely to occur:

Days/Times: _____ Settings: _____

Persons Present: _____ Activities: _____

What happens right BEFORE the problem behavior occurs?

What happens right AFTER the problem behavior occurs?

Describe the situations in which problem behavior is LEAST likely to occur:

Days/Times: _____ Settings: _____

Persons Present: _____ Activities: _____

Child Preferences

Please list things that appear to be child preferences. (Consider toys, activities, people, or behaviors that the child engages in/ with on a frequent basis.

Preferred Persons _____

Leisure Activities _____

Games or Toys _____

Videos, Music, Television Shows _____

Food, Snacks, Drinks _____

Favorite/ Frequently Visited Stores _____

Events _____

If left alone for a period of time, what will the child do? _____

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Expectations

Please describe your expectations of how ABA therapy will affect your child.

Preferred Therapy Schedule

(Please put an "√" in the boxes in which your child is available for therapy)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

Additional Information

In the space provided, please include any additional information that you feel may be useful.

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Behavioral Language Assessment

For the following questions in **bold**, circle the number next to the statement that best represents your child:

COOPERATION WITH ADULTS: How easy is it to work with the child?

1. Always uncooperative, avoids work, engages in negative behavior
2. Will do only one brief and easy response for a powerful reinforcer
3. Will give 5 responses without disruptive behavior
4. Will work for 5 minutes without disruptive behavior
5. Works well for 10 minutes at a table without disruptive behavior.

behavior
reinforcers
reinforcers
or pictures

MOTOR IMITATION: Does the child copy the actions of others? and words?

1. Cannot imitate anybody's motor movements
2. Imitates a few gross motor movements modeled by others
3. Imitates several gross motor movements on request
4. Imitates several fine and gross motor movements on request
5. Easily imitates any fine or gross movements, often spontaneously

intonations
a few words
understandable words

VOCAL IMITATION: Will the child repeat sounds or words?

1. Cannot repeat any sounds or words
2. Will repeat a few specific sounds or words
3. Will repeat or closely approximate several sounds or words
4. Will repeat or closely approximate many different words
5. Will clearly repeat any word or even simple phrases

sample
designs

RECEPTIVE: Does the child understand any words or follow directions?

1. Cannot understand any words
2. Will follow a few instructions related to daily routines
3. Will follow a few instructions to do actions or touch items
4. Can follow many instructions and point to at least 25 items
5. Can point to at least 100 items, actions, persons, or adjectives

sentences

RECEPTIVE BY FUNCTION, FEATURE, AND CLASS: Does the words or answer child identify items when given information about those items?

1. Cannot identify items based on information about them
2. Will identify a few items given synonyms or common functions
3. Will identify 10 items given 1 of 3 functions or features
4. Will identify 25 items given 4 functions, features, or classes
5. Will identify 100 items given 5 functions, features, or classes

sounds
with variation

REQUESTS: How does the child let his/her needs and wants be known?

1. Cannot ask for reinforcers, or engages in negative
2. Pulls people, points, or stands by reinforcing items
3. Uses 1-5 words, signs, or pictures to ask for
4. Uses 5-10 words, signs, or pictures to ask for
5. Frequently requests using 10 or more words, signs,

VOCAL PLAY: Does the child spontaneously say sounds

1. Does not make any sounds (mute)
2. Makes a few speech sounds at a low rate
3. Vocalizes many speech sounds with varied
4. Vocalizes frequently with varied intonation and says
5. Vocalizes frequently and says many clearly

MATCH-TO-SAMPLE: Will the child match objects, pictures, and designs to presented samples?

1. Cannot match any objects or pictures to a sample
2. Can match 1 or 2 objects or pictures to a sample
3. Can match 5 to 10 objects or pictures to a sample
4. Can match 5 to 10 colors, shapes, or designs to a
5. Can match most items and match 2 to 4 block

LABELING: Does the child label or verbally identify any items or actions?

1. Cannot identify any items or actions
2. Identifies only 1 to 5 items or actions
3. Identifies 6 to 15 items or actions
4. Identifies 16 to 50 items or actions
5. Identifies over 100 items or actions and emits short

CONVERSATIONAL SKILLS: Can the child fill-in missing questions?

1. Cannot fill-in missing words or parts of songs
2. Can fill-in a few missing words or provide animal
3. Can fill-in 10 non-reinforcing phrases or answer at least 10 simple questions
4. Can fill-in 20 phrases or can answer 20 questions
5. Can answer at least 30 questions with variation

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LETTERS AND NUMBERS: Does the child know any letters, interactions numbers, or written words?

1. Cannot identify any letters, numbers or written words
2. Can identify at least 3 letters or numbers
3. Can identify at least 15 letters or numbers
4. Can read at least 5 words and identify 5 numbers
5. Can read at least 25 words and identify 10 numbers with peers

SOCIAL INTERACTION: Does the child initiate and sustain with others?

1. Does not initiate interactions with others
2. Physically approaches others to initiate an interaction
3. Readily asks adults for reinforcers
4. Verbally interacts with peers with prompts
5. Regularly initiates and sustains verbal interactions